FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038752

Facility Name: FAIRFAX NURSING HOME, INC.

Address: 3601 S. Harlem Avenue (Number) Berwyn (City) 60402 (Zip Code)

County: Cook

Telephone Number: (708) 749-4160 **Fax #** (708) 749-7696

IDPA ID Number: 36-3874607

Date of Initial License for Current Owners: 3/31/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Edward Slack, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,560	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,725		2,940	6,665	8
9	SNF/PED					9
10	ICF	28,318	11,362	2,591	42,271	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,043	11,362	5,531	48,936	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.57%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/16/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/16/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 2,940

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	196,894	45,171	15,030	257,095		257,095	(4,346)	252,749			1
2	Food Purchase		169,122		169,122	(21,740)	147,382	1,909	149,291			2
3	Housekeeping	159,651	33,989		193,640		193,640	1,738	195,378			3
4	Laundry	94,076	21,367		115,443		115,443		115,443			4
5	Heat and Other Utilities			102,903	102,903		102,903	1,333	104,236			5
6	Maintenance	56,691		106,664	163,355		163,355	(63)	163,292			6
7	Other (specify):*							1,828	1,828			7
8	**TOTAL General Services**	507,312	269,649	224,597	1,001,558	(21,740)	979,818	2,399	982,217			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	2,143,155	137,304	130,336	2,410,795		2,410,795	(23,420)	2,387,375			10
10a	Therapy	85,510	1,951	29,801	117,262		117,262	(12,241)	105,021			10a
11	Activities	109,454	10,466	4,603	124,523		124,523	(856)	123,667			11
12	Social Services	70,267		2,909	73,176		73,176	(1,355)	71,821			12
13	Nurse Aide Training			290	290		290		290			13
14	Program Transportation											14
15	Other (specify):*							8,558	8,558			15
16	**TOTAL Health Care and Programs**	2,408,386	149,721	186,939	2,745,046		2,745,046	(29,313)	2,715,733			16
	C. General Administration											
17	Administrative			82,506	82,506		82,506	28,139	110,645			17
18	Directors Fees											18
19	Professional Services			256,704	256,704		256,704	(221,031)	35,673			19
20	Dues, Fees, Subscriptions & Promotions			87,768	87,768		87,768	(30,699)	57,069			20
21	Clerical & General Office Expenses	124,638	23,749	204,731	353,118		353,118	(68,085)	285,033			21
22	Employee Benefits & Payroll Taxes			529,613	529,613	21,740	551,353	(26,603)	524,750			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,689	8,689		8,689	3,868	12,557			24
25	Other Admin. Staff Transportation			3,377	3,377		3,377	(1,975)	1,402			25
26	Insurance-Prop.Liab.Malpractice			97,352	97,352		97,352	888	98,240			26
27	Other (specify):*							24,974	24,974			27
28	**TOTAL General Administration**	124,638	23,749	1,270,740	1,419,127	21,740	1,440,867	(290,525)	1,150,342			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,040,336	443,119	1,682,276	5,165,731		5,165,731	(317,439)	4,848,292			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

FAIRFAX NURSING HOME, INC.
0038752
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	21,740	
2	FOOD		21,740

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number FAIRFAX NURSING HOME, INC. #0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			69,159	69,159		69,159	229,826	298,985			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,288	176,288		176,288	422,655	598,943			32
33	Real Estate Taxes			259,554	259,554		259,554	1,805	261,359			33
34	Rent-Facility & Grounds			732,400	732,400		732,400	(726,548)	5,852			34
35	Rent-Equipment & Vehicles			3,660	3,660		3,660	2,847	6,507			35
36	Other (specify):*			843	843		843	11,125	11,968			36
37	**TOTAL Ownership**			1,241,904	1,241,904		1,241,904	(58,290)	1,183,614			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	310,917	276,906	207,101	794,924		794,924	(46,705)	748,219			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,840	87,840		87,840		87,840			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	310,917	276,906	294,941	882,764		882,764	(46,705)	836,059			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,351,253	720,025	3,219,121	7,290,399		7,290,399	(422,434)	6,867,965			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(30)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	27,424	30		9
10	Interest and Other Investment Income	(8,973)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(388)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(139,304)	21		24
25	Fund Raising, Advertising and Promotional	(16,251)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,054)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(669)	20		28
29	Other-Attach Schedule	(46,659)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (187,954)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(234,481)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (234,481)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (422,434)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FAIRFAX NURSING HOME, INC.

ID# 0038752

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Jury Duty Income	(52)	10	2
3	VA Expense	(24,662)	10	3
4	Collection Expense	(987)	21	4
5	Theft Loss	(1,209)	21	5
6	Shareholders Interest	(17,805)	32	6
7	Donation - ICLTC	(219)	20	7
8	Non-allowable legal costs	(1,725)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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22				22
23				23
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(46,659)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			4,146	(5,840)		(2,652)						(4,346)	1
2	Food Purchase	(418)		(882)			3,209						1,909	2
3	Housekeeping			1,738									1,738	3
4	Laundry													4
5	Heat and Other Utilities			1,333									1,333	5
6	Maintenance			10,909	(10,987)		15						(63)	6
7	Other (specify):*			1,670			158						1,828	7
8	**TOTAL General Services**	(418)		18,915	(16,827)		730						2,399	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(24,714)		21,041	(44,582)	34,801	2			(9,968)			(23,420)	10
10a	Therapy			4,064	(16,305)								(12,241)	10a
11	Activities			1,763	(2,619)								(856)	11
12	Social Services			1,554	(2,909)								(1,355)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,626		4,932							8,558	15
16	**TOTAL Health Care and Programs**	(24,714)		32,048	(66,414)	39,733	2			(9,968)			(29,313)	16
	C. General Administration													
17	Administrative			28,055	(74,459)	74,459	84						28,139	17
18	Directors Fees													18
19	Professional Services	(1,725)	2,133	7,386	(228,850)		25						(221,031)	19
20	Fees, Subscriptions & Promotions	(17,189)		1,084	(14,600)		6						(30,699)	20
21	Clerical & General Office Expenses	(144,554)	1,962	99,917	(25,493)		83						(68,085)	21
22	Employee Benefits & Payroll Taxes				(26,603)								(26,603)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,863			5						3,868	24
25	Other Admin. Staff Transportation			172	(2,292)		145						(1,975)	25
26	Insurance-Prop.Liab.Malpractice			888									888	26
27	Other (specify):*			14,762		10,212							24,974	27
28	**TOTAL General Administration**	(163,468)	4,095	156,127	(372,298)	84,671	348						(290,525)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(188,600)	4,095	207,090	(455,540)	124,404	1,080			(9,968)			(317,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	27,424	143,388	9,322					49,692				229,826	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(26,778)	423,746	10,093			5		15,589				422,655	32
33	Real Estate Taxes			1,805									1,805	33
34	Rent-Facility & Grounds		(730,000)	3,452									(726,548)	34
35	Rent-Equipment & Vehicles			2,840			7						2,847	35
36	Other (specify):*		11,125										11,125	36
37	**TOTAL Ownership**	646	(151,741)	27,512			12		65,281				(58,290)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,225)		(43,480)				(46,705)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(3,225)		(43,480)				(46,705)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(187,954)	(147,646)	234,602	(455,540)	124,404	(2,133)		21,801	(9,968)			(422,434)	45

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Fairfax Health Care Properties		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 730,000	Fairfax Health Care Properties	100.00%	$	$ (730,000)	1
2	V	32	Interest Income		Fairfax Health Care Properties	100.00%	(191,792)	(191,792)	2
3	V	32	Interest Expense		Fairfax Health Care Properties	100.00%	615,538	615,538	3
4	V	19	Consulting		Fairfax Health Care Properties	100.00%	2,133	2,133	4
5	V	21	Bank Charges		Fairfax Health Care Properties	100.00%	8	8	5
6	V	36	Amortization		Fairfax Health Care Properties	100.00%	11,125	11,125	6
7	V	30	Depreciation		Fairfax Health Care Properties	100.00%	143,388	143,388	7
8	V	21	Illinois Replacement Tax		Fairfax Health Care Properties	100.00%	1,954	1,954	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 730,000			$ 582,354	$ * (147,646)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 4,146	$ 4,146	15
16	V	2	FOOD				(882)	(882)	16
17	V	3	HOUSEKEEPING				1,738	1,738	17
18	V	5	UTILITIES				1,333	1,333	18
19	V	6	REPAIRS AND MAINT.				10,909	10,909	19
20	V	7	EMP. BEN. - GEN. SERV.				1,670	1,670	20
21	V	10	NURSING				21,041	21,041	21
22	V	10A	THERAPY				4,064	4,064	22
23	V	11	ACTIVITIES				1,763	1,763	23
24	V	12	SOCIAL SERVICES				1,554	1,554	24
25	V	15	EMP. BEN. - HEALTHCARE				3,626	3,626	25
26	V	17	ADMINISTRATIVE				28,055	28,055	26
27	V	19	PROFESSIONAL FEES				7,386	7,386	27
28	V	20	DUES, SUBSCRIPTIONS				1,084	1,084	28
29	V	21	CLERICAL AND GENERAL				99,917	99,917	29
30	V	24	SEMINARS				3,863	3,863	30
31	V	25	AUTO EXPENSE				172	172	31
32	V	26	INSURANCE				888	888	32
33	V	27	EMP. BEN. - GEN. ADMIN.				14,762	14,762	33
34	V	30	DEPRECIATION				9,322	9,322	34
35	V	32	INTEREST	0			10,093	10,093	35
36	V	33	REAL ESTATE TAXES				1,805	1,805	36
37	V	34	BUILDING RENT - UNRELATED				3,452	3,452	37
38	V	35	EQUIPMENT RENTAL				2,840	2,840	38
39	Total			$			$ 234,602	$ * 234,602	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 5,840	CARE CENTERS, INC.	100.00%	$ 0	$ (5,840)	15
16	V	19	ACCOUNTING	15,000			0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	19,200			0	(19,200)	17
18	V	19	BOOKEEPING	32,640			0	(32,640)	18
19	V	19	DATA PROCESSING	5,760			0	(5,760)	19
20	V	19	LEGAL	14,600			0	(14,600)	20
21	V	19	MANAGEMENT FEE	134,400			0	(134,400)	21
22	V	19	PROFESSIONAL FEES	7,250			0	(7,250)	22
23	V	20	ADVERTISING	14,600			0	(14,600)	23
24	V	25	REBILL BUS	2,292			0	(2,292)	24
25	V	0					0		25
26	V	22	HOME OFFICE PAYROLL TAX	26,603			0	(26,603)	26
27	V	1	REBILL. PAYROLL DIETARY	0			0		27
28	V	3	REBILL. PAYROLL HSKPNG	0			0		28
29	V	6	REBILL. PAYROLL MAINT.	10,987			0	(10,987)	29
30	V	10	REBILL. PAYROLL NURSING	44,582			0	(44,582)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	16,305			0	(16,305)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	2,619			0	(2,619)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	2,909			0	(2,909)	33
34	V	17	REBILL. PAYROLL ADMIN.	74,459			0	(74,459)	34
35	V	21	REBILL. PAYROLL CLERICAL	25,493			0	(25,493)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 455,540			$ 0	$ * (455,540)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 34,801	$ 34,801	15
16	V	15	EMP. BEN HEALTHCARE				4,932	4,932	16
17	V	17	ADMINISTRATIVE				74,459	74,459	17
18	V	27	EMP. BEN GEN. ADMIN.				10,212	10,212	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 124,404	$ * 124,404	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION, INC.	100.00%	$ 1,658	$ 1,658	15
16	V	2	FOOD				3,209	3,209	16
17	V	6	MAINTENANCE				15	15	17
18	V	7	EMP. BEN. - GEN. SERV.				158	158	18
19	V	10	NURSING				2	2	19
20	V	17	ADMINISTRATIVE				84	84	20
21	V	19	PROFESSIONAL FEES				25	25	21
22	V	20	DUES, FEES, SUB.				6	6	22
23	V	21	CLERICAL & GENERAL				83	83	23
24	V	24	SEMINARS				5	5	24
25	V	25	TRAVEL				145	145	25
26	V	32	INTEREST				5	5	26
27	V	35	RENT - EQUIPMENT & VEHICLES				7	7	27
28	V	39	ANCILLARY ENTERAL SUPPLIES				108	108	28
29	V	1	DIETARY SUPP	4,310			0	(4,310)	29
30	V	39	ANCILLARY SUPP	3,333			0	(3,333)	30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,643			$ 5,510	$ * (2,133)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	VENTLEASE LLC	100.00%	$ 49,692	$ 49,692	15
16	V	32	INTEREST				15,589	15,589	16
17	V								17
18	V								18
19	V	39	ANCILLARY EQUIP RENT	43,480				(43,480)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 43,480			$ 65,281	$ * 21,801	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 52,548	$ 52,548	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	62,516				(62,516)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 62,516				$ 52,548	$ * (9,968)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 74,646	$ 74,646	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	74,646				(74,646)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,646			$ 74,646	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	26.81	see attached	1.59	2.21		$		1
2	Norm Goldberg	Owner	Administrative	0.34	see attached	1.62	3.24	salary alloc.	2,940	17-7	2
3	Jim Goodsite	Owner	Administrative	0.34	see attached	1.62	3.24	salary alloc.	4,212	17-7	3
4	Mark Steinberg	Relative	Administrative		see attached	1.62	3.24	salary alloc.	1,436	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,588		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	48,936	$ 4,146	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		48,936	(882)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	48,936	1,738	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		48,936	1,333	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	48,936	10,909	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		48,936	1,670	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	48,936	21,041	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	48,936	4,064	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	48,936	1,763	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	48,936	1,554	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		48,936	3,626	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	48,936	28,055	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		48,936	7,386	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		48,936	1,084	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	48,936	99,917	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		48,936	3,863	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		48,936	172	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		48,936	888	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		48,936	14,762	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		48,936	9,322	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		48,936	10,093	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		48,936	1,805	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		48,936	3,452	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		48,936	2,840	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 234,602	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		34,801	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			4,932	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		74,459	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			10,212	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 124,404	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	7,644	1,658	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		7,644	3,209	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		7,644	15	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		7,644	158	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		7,644	2	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		7,644	84	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		7,644	25	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		7,644	6	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		7,644	83	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		7,644	5	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		7,644	145	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		7,644	5	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		7,644	7	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		7,644	108	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 5,510	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: VENTLEASE LLC
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT ALLOCATION			$	$		$ 49,692	1
2	32	INTEREST	DIRECT ALLOCATION						15,589	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 65,281	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 52,548	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 52,548	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 74,646	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 74,646	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Nomura		X	Mortgage			$	$ 6,767,467			$ 615,538	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholders Loans	X		Working Capital				175,000			17,805	6
7				Insurance Financing							1,399	7
8	Diawa		X	Line of Credit				837,794			43,949	8
9	TOTAL Facility Related						$	$ 7,780,261			$ 678,691	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(61,940)	10
11	Less: nonallowable interest										(17,805)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (79,745)	14
15	TOTALS (line 9+line14)						$	$ 7,780,261			$ 598,946	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (8,973)	1
2	Interest Income (Bldg Co.)										(78,654)	2
3	Care Center Allocation										10,098	3
4	Ventlease Allocation										15,589	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (61,940)	21

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	186,966	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	223,861	2
3. Under or (over) accrual (line 2 minus line 1).	$	36,895	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	224,464	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	261,359	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	163,520	8
	1996	178,206	9
	1997	184,115	10
	1998	206,946	11
	1999	222,056	12

2000 Accrual = 1999 expense + 5% - interest income on escrow account

$222,056 x 105% =$ 233,159 - 8695 = $224,464

Line 2 includes RE Tax allocated from CCI of $1,805

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,431 B. General Construction Type: Exterior Brick Frame Concrete Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1994	$ 50,387	1
2	Alloc from Care Center		1998	2,071	2
3	TOTALS			$ 52,458	3

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 2,906,534	$ 74,527	20	$ 145,327	$ 70,800	$ 823,520	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	21,055	539	20	1,053	514	7,880	9
10	Various			1994	115,390	2,959	20	5,770	2,811	36,744	10
11	Various			1995	20,692	532	20	1,033	501	5,518	11
12	PLUMBING RENOV			1996	583	15	20	29	14	143	12
13	ELEVATOR RENOV			1996	2,499	64	20	125	61	552	13
14	ELEVATOR RENOV			1996	1,376	35	20	69	34	305	14
15	ELEVATOR RENOV			1996	2,547	65	20	127	62	572	15
16	BREATH CALL SYST			1996	565	14	20	28	14	133	16
17	PLUMBING RENOV			1996	503	13	20	25	12	115	17
18	PLUMBING RENOV			1996	2,191	56	20	110	54	486	18
19	PLUMBING RENOV			1996	4,275	110	20	214	104	981	19
20	PLUMBING RENOV			1996	524	13	20	26	13	130	20
21	ELEVATOR RENOV			1996	784	20	20	39	19	188	21
22	CORNERGUARDS			1996	711	18	20	36	18	156	22
23	PAINTING & DECOR			1996	54,480	1,397	20	2,724	1,327	12,712	23
24											24
25	PAGE 12-1 REP TOTALS				46,138	1,228		1,530	302	6,145	25
26											26
27											27
28											28
29	PAGE 12G TOTALS				37,521	1,303		569	(734)	569	29
30	PAGE 12F TOTALS				45,027	3,340		1,969	(1,371)	1,969	30
31	PAGE 12E TOTALS				79,806	2,029		3,969	1,940	6,855	31
32	PAGE 12D TOTALS				84,365	2,793		4,223	1,430	9,846	32
33	PAGE 12C TOTALS				68,302	1,718		3,416	1,698	8,745	33
34	PAGE 12B TOTALS				137,922	3,536		6,899	3,363	21,330	34
35	PAGE 12A TOTALS				143,811	6,764		7,191	427	25,159	35
36	TOTAL (lines 4 thru 35)				$ 3,777,601	$ 103,088		$ 186,501	$ 83,413	$ 970,753	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DRAPERY			1996	41,148	4,131	20	2,057	(2,074)	4,114	9
10	PAINTING& DECORATING			1996	1,650	42	20	83	41	339	10
11	COLUMN BASE			1996	931	24	20	47	23	204	11
12	NURSE STATION			1996	24,279	623	20	1,214	591	5,362	12
13	WALLPAPER			1996	23,006	590	20	1,150	560	5,271	13
14	WALL PROTECTORS			1996	1,851	47	20	93	46	380	14
15	TILE			1996	977	25	20	49	24	200	15
16	PLUMBING RENOV			1996	759	19	20	38	19	155	16
17	ROOM SIGNS			1996	2,566	66	20	128	62	544	17
18	CARPET CAPS			1996	1,200	31	20	60	29	255	18
19	WALLCOVERING			1996	1,577	40	20	79	39	342	19
20	HANDRAILS			1996	10,307	264	20	515	251	2,360	20
21	WALLPAPER			1996	1,568	40	20	78	38	344	21
22	CORNER GUARDS			1996	532	14	20	27	13	115	22
23	NURSE STATION			1996			20				23
24	HVAC RENOV			1997	3,328	85	20	166	81	567	24
25	TILE RENOV			1997	2,283	59	20	114	55	361	25
26	ELECTRICAL RENOV			1997	3,422	88	20	171	83	570	26
27	FLOOR RENOV			1997	5,886	151	20	294	143	1,005	27
28	HVAC RENOV			1997	1,350	35	20	68	33	210	28
29	PLUMBING RENOV			1997	4,760	122	20	238	116	754	29
30	FIRE SYSTEM			1997	3,120	80	20	156	76	507	30
31	PLUMBING RENOV			1997	1,137	29	20	57	28	185	31
32	ROOF FLASHING			1997	749	19	20	37	18	126	32
33	ROOF RENOV			1997	1,700	44	20	85	41	262	33
34	DRYWALL			1997	850	22	20	43	21	147	34
35	HVAC RENOV			1997	2,875	74	20	144	70	480	35
36	TOTAL (lines 4 thru 35)				$ 143,811	$ 6,764		$ 7,191	$ 427	$ 25,159	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			1997	7,315	188	20	366	178	1,251	9
10	WALLCOVERING			1997	714	18	20	36	18	120	10
11	WINDOWS			1997	750	19	20	38	19	139	11
12	PLUMBING RENOVATION			1997	1,545	40	20	77	37	289	12
13	PLUMBING RENOV			1997	1,588	41	20	79	38	263	13
14	FLOOR RENOVATION			1997	3,055	78	20	153	75	536	14
15	PLUMBING RENOV			1997	530	14	20	27	13	83	15
16	WINDOWS			1997	1,610	41	20	81	40	324	16
17	FLOOR TILE INSTALL			1997	985	25	20	49	24	184	17
18	BLDG RENOVATION			1997	560	14	20	28	14	98	18
19	FLOORING			1997	2,505	64	20	125	61	448	19
20	CUBICLE CURTAINS			1997	1,520	39	20	76	37	272	20
21	PLUMBING RENOVATION			1997	885	23	20	44	21	161	21
22	HVAC RENOVATION			1997	1,735	44	20	87	43	319	22
23	VENT PIPE			1997	521	13	20	26	13	100	23
24	PLUMBING INSTALL			1997	960	25	20	48	23	192	24
25	WINDOW CCR RENOV			1997	1,052	27	20	53	26	199	25
26	COOLER FLOOR			1997	895	23	20	45	22	169	26
27	PLUMBING RENOVATION			1997	1,094	28	20	55	27	211	27
28	WALK IN COOLER REN			1997	895	23	20	45	22	173	28
29	BREATHCELL UNIT			1997	680	17	20	34	17	130	29
30	FLOOR RENOVATION			1997	2,239	57	20	112	55	448	30
31	BLDG RENOVATION			1997	550	14	20	28	14	103	31
32	PLUMBING RENOV			1998	15,425	396	20	771	375	2,313	32
33	HVAC RENOV			1998	1,447	37	20	72	35	156	33
34	WINDOWS			1998	1,312	34	20	66	32	171	34
35	CENTRAL STATION			1998	85,555	2,194	20	4,278	2,084	12,478	35
36	TOTAL (lines 4 thru 35)				$ 137,922	$ 3,536		$ 6,899	$ 3,363	$ 21,330	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COUNTER TOPS			1998	2,575	66	20	129	63	280	9
10	ELECTRICAL			1998	1,483	38	20	74	36	191	10
11	HVAC RENOV			1998	1,157	30	20	58	28	174	11
12	COOLER RENOVATION			1998	1,646		20	82	82	198	12
13	PLASTER			1998	1,000	26	20	50	24	113	13
14	ELECTRICA			1998	851	22	20	43	21	115	14
15	CUBICLE CURTAINS			1998	2,525	65	20	126	61	347	15
16	HVAC RENOV			1998	5,266	135	20	263	128	679	16
17	WALLPAPER			1998	6,319	162	20	316	154	869	17
18	SHOWER RENOV			1998	9,739	250	20	487	237	1,339	18
19	NURSE CALL SYSTEM			1998	3,960		20	198	198	528	19
20	REFRIGERATOR RENOV			1998			20				20
21	DOOR			1998	762	20	20	38	18	98	21
22	AVIARY			1998	11,968	307	20	598	291	1,445	22
23	CUBICLE CURTAINS			1998	4,250	109	20	213	104	568	23
24	NEON'S			1998	1,580	41	20	79	38	191	24
25	PLUMBING			1998	1,991	51	20	100	49	283	25
26	HVAC RENOV			1998	3,393	87	20	170	83	383	26
27	AQUARIUM			1998			20				27
28	CLEAN SUMP PUMP			1998	525	13	20	26	13	65	28
29	PAINTING			1998	575	15	20	29	14	70	29
30	DRYWALL			1998	2,500	64	20	125	61	313	30
31	GENERATOR RENOVATION			1998	658	126	20	33	(93)	80	31
32	ELECTRICAL RENOV			1998	521	13	20	26	13	56	32
33	HVAC RENOV			1998	660	17	20	33	16	80	33
34	LOUVERS			1998	1,794	46	20	90	44	210	34
35	PLUMBING RENOV			1998	604	15	20	30	15	70	35
36	TOTAL (lines 4 thru 35)				$ 68,302	$ 1,718		$ 3,416	$ 1,698	$ 8,745	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SECURITY SYSTEM			1998	1,250	240	20	63	(177)	189	9
10	ELECTRICAL			1998	2,024	52	20	101	49	286	10
11	NOMAI PATIO LIGHTS			1998	805	141	20	40	(101)	120	11
12	ROOF REPAIR			1998	4,300	110	20	215	105	538	12
13	COUNTER TOPS			1998	1,950	50	20	98	48	221	13
14	CENTRAL SYSTEM			1998	8,374	215	20	419	204	1,187	14
15	ROOFING			1998	850	22	20	43	21	125	15
16	TUCKPOINTING			1998	850	22	20	43	21	97	16
17	WALLPAPER REMOVAL			1998	950	24	20	48	24	108	17
18	FLOOR			1998	4,773	122	20	239	117	617	18
19	HVAC RENOV			1998	7,886	202	20	394	192	1,018	19
20	CRASH RAILS			1998	13,553	348	20	678	330	1,808	20
21	PLUMBING REP			1999	7,484	192	20	374	182	655	21
22	TILES			1999	8,000	205	20	400	195	767	22
23	TILE-3RD FLOOR			1999	2,650	68	20	133	65	266	23
24	TILE-3RD FLOOR			1999	625	316	20	31	(285)	62	24
25	PLUMBING			1999	8,644	222	20	432	210	864	25
26	PLUMBING			1999	1,133	29	20	57	28	114	26
27	PLUMBING			1999	1,197	31	20	60	29	120	27
28	HVAC REPAIR			1999	630	16	20	32	16	64	28
29	NEW TILES-SHOWER			1999	611	16	20	31	15	54	29
30	VINYL TILES			1999	516	13	20	26	13	48	30
31	HOT WATER TANK REP			1999	2,300	59	20	115	56	230	31
32	HVAC REPAIR			1999	571	15	20	29	14	56	32
33	PAINT			1999	1,277	33	20	64	31	123	33
34	WALLPAPER			1999	535	14	20	27	13	47	34
35	GENERATOR REPAIR			1999	627	16	20	31	15	62	35
36	TOTAL (lines 4 thru 35)				$ 84,365	$ 2,793		$ 4,223	$ 1,430	$ 9,846	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINTING-2ND FLOOR			1999	1,650	42	20	83	41	152	9
10	DOORS			1999	13,074	335	20	654	319	1,199	10
11	GENERATOR REPAIR			1999	503	13	20	25	12	50	11
12	DOORS			1999	1,092	28	20	55	27	96	12
13	PLUMBING WORK			1999	1,225	31	20	61	30	81	13
14	TILES			1999	3,522	90	20	176	86	337	14
15	UCT INSTALLATION			1999	245	6	20	12	6	15	15
16	FIXTURES			1999	2,014	52	20	101	49	185	16
17	PLUMBING - 2ND FLOOR			1999	657	17	20	33	16	61	17
18	REMODELING-9 PT ROOM			1999	17,533	450	20	877	427	1,608	18
19	ELECTRICAL WIRING			1999	795	20	20	40	20	73	19
20	PLUMBING-KITCHEN			1999	3,030	78	20	152	74	279	20
21	TILES-KITCHEN			1999	9,004	231	20	450	219	825	21
22	GENERATOR RENOV			1999	1,163	30	20	58	28	97	22
23	ELEVATOR REPAIR			1999	938	24	20	47	23	67	23
24	FIRE SYSTEM REPAIR			1999	1,520	39	20	76	37	108	24
25	ELECTRICAL REPAIR			1999	3,310	85	20	166	81	304	25
26	DOORS			1999	4,328	111	20	216	105	270	26
27	VERTICAL BLINDS			1999	589	15	20	29	14	53	27
28	RENOVATION-9 ROOMS			1999	5,100	131	20	255	124	489	28
29	PLUMBING REPAIR			1999	2,173	56	20	109	53	154	29
30	METAL DOOR			1999	618	16	20	31	15	47	30
31	PAINTING			1999	1,800	46	20	90	44	120	31
32	AC REPAIR			1999	574	15	20	29	14	41	32
33	PLUMBING REPAIR			2000	828	18	20	38	20	38	33
34	PLUMBING RENOVATION			2000	671	13	20	28	15	28	34
35	DECORATING			2000	1,850	37	20	78	41	78	35
36	TOTAL (lines 4 thru 35)				$ 79,806	$ 2,029		$ 3,969	$ 1,940	$ 6,855	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DECORATING			2000	1,900	39	20	79	40	79	9
10	WIRING-LOBBY CEILING			2000	2,073	24	20	52	28	52	10
11	FIRE SYSTEM UPGRADE			2000	685	14	20	28	14	28	11
12	PLUMBING REPAIR			2000	1,791	40	20	83	43	83	12
13	BOILER REPAIR			2000	758	17	20	35	18	35	13
14	PLUMBING REPAIR			2000	643	15	20	32	17	32	14
15	VINYL TILE			2000	7,150	130	20	269	139	269	15
16	A/C REPAIR			2000	509	12	20	25	13	25	16
17	PLUMBING REPAIR			2000	1,469	36	20	73	37	73	17
18	PLUMBING REPAIR			2000	301	8	20	15	7	15	18
19	ELECTRICAL REPAIR			2000	8,012	1,603	20	401	(1,202)	401	19
20	PLUMBING RENOVATION			2000	832	15	20	32	17	32	20
21	CHAIRRAILS			2000	1,430	286	20	107	(179)	107	21
22	FLOOR			2000	830	13	20	28	15	28	22
23	PLUMBING			2000	3,218	52	20	107	55	107	23
24	WIRING			2000	1,050	17	20	35	18	35	24
25	WIRING			2000	1,735	28	20	58	30	58	25
26	PLUMBING			2000	1,194	239	20	69	(170)	69	26
27	CHAIRRAIL			2000	889	178	20	52	(126)	52	27
28	WIRING			2000	550	8	20	16	8	16	28
29	WIRING			2000	140	2	20	4	2	4	29
30	DOOR EXIT DEVICE			2000	869	174	20	65	(109)	65	30
31	SHIPPING CHARGES VCT			2000	431	4	20	9	5	9	31
32	DOOR KNOBS			2000	781	156	20	78	(78)	78	32
33	TILING			2000	4,190	49	20	105	56	105	33
34	TELEPHONE SYSTEM			2000	1,247	178	20	104	(74)	104	34
35	TUCKPOINTING			2000	350	3	20	8	5	8	35
36	TOTAL (lines 4 thru 35)				$ 45,027	$ 3,340		$ 1,969	$ (1,371)	$ 1,969	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PHONE SYSTEM REPAIR			2000	383	77	20	6	(71)	6	9
10	DUCKWORK			2000	565	5	20	12	7	12	10
11	MIRRORS			2000	4,506	44	20	94	50	94	11
12	WIRING			2000	610	6	20	13	7	13	12
13	FIRE ALARM REPAIR			2000	1,143	1	20	5	4	5	13
14	SLOPE TOP FIN TUBE			2000	5,228	28	20	65	37	65	14
15	COUNTERTOP			2000	4,357	872	20	109	(763)	109	15
16	INSTALLATION OF DRAP			2000	857	5	20	11	6	11	16
17	WIRING IN KITCHEN			2000	610	3	20	8	5	8	17
18	HEAT DETECTOR REPAIR			2000	824	8	20	17	9	17	18
19	PHONES			2000	804	161	20	13	(148)	13	19
20	DOOR SYSTEMS			2000	1,424	8	20	18	10	18	20
21	PAINTING HAZARD ROOM			2000	1,850	14	20	31	17	31	21
22	PLUMBING REPAIR 2&3			2000	1,500	11	20	25	14	25	22
23	BOILER #2 REPAIR			2000	1,038	8	20	17	9	17	23
24	BOILER #3 REPAIR			2000	870	6	20	15	9	15	24
25	SHOWER ROOM FIN TUBE			2000	1,330	10	20	22	12	22	25
26	PLUMBING REPAIR			2000	1,231	9	20	21	12	21	26
27	PUMP MOTOR			2000	1,040	1	20	4	3	4	27
28	PUMP MOTOR			2000	533	1	20	2	1	2	28
29	SEWER REPAIR			2000	744	1	20	3	2	3	29
30	SEWER REPAIR			2000	3,504	4	20	15	11	15	30
31	PLUMBING REPAIR			2000	624	1	20	3	2	3	31
32	DRAPES			2000	1,946	19	20	40	21	40	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 37,521	$ 1,303		$ 569	$ (734)	$ 569	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1996	CCI Alloc	$ 36,652	$ 940	35	$ 1,047	$ 107	$ 4,276	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers, Inc.			2000	44	1	20	2	1	2	9
10	Allocation from Care Centers, Inc.			1999	656	17	20	33	16	62	10
11	Allocation from Care Centers, Inc.			1998	271	7	20	14	7	36	11
12	Allocation from Care Centers, Inc.			1997	3,844	88	20	212	124	1,027	12
13	Allocation from Care Centers, Inc.			1996	4,225	56	20	203	147	698	13
14	Allocation from Care Centers, Inc.			1997	446	103	20	19	(84)	44	14
15	Allocation from Care Centers, Inc.			1994		12	20		(12)		15
16	Allocation from Care Centers, Inc.			1993		4	20		(4)		16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 46,138	$ 1,228		$ 1,530	$ 302	$ 6,145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,055,542	$ 153,027	$ 105,776	$ (47,251)		$ 551,601	37
38	Current Year Purchases	66,411	11,658	4,022	(7,636)		4,022	38
39	Fully Depreciated Assets		16		(16)			39
40								40
41	TOTALS	$ 1,121,953	$ 164,701	$ 109,798	$ (54,903)		$ 555,623	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocation from Care Center			$ 17,410	$ 3,772	$ 2,686	$ (1,086)	10	$ 6,027	42
43										43
44										44
45										45
46	TOTALS			$ 17,410	$ 3,772	$ 2,686	$ (1,086)		$ 6,027	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,969,422	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 271,561	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 298,985	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 27,424	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,532,403	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

FAIRFAX NURSING HOME, INC.
0038752
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Fairfax Nursing Home, Inc.	259,568	30,453	25,926	(4,527)	103,753
Fairfax Health Care Properties	764,890	68,861	76,489	7,628	433,438
Care Centers, Inc.	31,084	4,021	3,361	(660)	14,410
Ventlease LLC		49,692		(49,692)	
TOTALS	1,055,542	153,027	105,776	(47,251)	551,601
LINE 29: CURRENT YEAR					
Fairfax Nursing Home, Inc.	64,660	11,357	3,981	(7,376)	3,981
Fairfax Health Care Properties					
Care Centers, Inc.	1,751	301	41	(260)	41
Ventlease LLC					
TOTALS	66,411	11,658	4,022	(7,636)	4,022
LINE 30: FULLY DEPRECIATED					
Fairfax Nursing Home, Inc.		16		(16)	
Fairfax Health Care Properties					
Care Centers, Inc.					
Ventlease LLC					
TOTALS		16		(16)	
TOTALS (Should Tie to Totals on Page 13)					
Fairfax Nursing Home, Inc.	324,228	41,826	29,907	(11,919)	107,734
Fairfax Health Care Properties	764,890	68,861	76,489	7,628	433,438
Care Centers, Inc.	32,835	4,322	3,402	(920)	14,451
Ventlease LLC		49,692		(49,692)	
TOTALS	1,121,953	164,701	109,798	(54,903)	555,623

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Parking Lot Rental				2,400			5
6	Alloc from Care Centers, Inc.				3,452			6
7	TOTAL				$ 5,852 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,507 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 290	$	$ 290
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 290	$	$ 290
10	SUM OF line 9, col. 1 and 2 (e)	$ 290			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 88,108	$		$ 88,108	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			15,396			15,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			102,704			102,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				57,718		57,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1		310,917		893			311,810	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					219,188		219,188	13
14	TOTAL			$ 310,917		$ 207,101	$ 276,906		$ 794,924	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	48,554
2	Air Fluid Beds	24,923
3	Oxygen	1,443
4	Enteral	5,305
5	Respiratory Supplies	87,986
6	Radiology	2,708
7	Lab	1,669
8	Vent Equipment Rental	46,600
9		
10		
		219,188

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,212	$ 38,437	1
2	Cash-Patient Deposits	50,841	50,841	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,576,991	1,576,991	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,812	241,812	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,791,103)	2,715,000	8
9	Other(specify): See supplemental schedule	34,986	40,944	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 118,739	$ 4,664,025	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		575,177	13
14	Buildings, at Historical Cost		2,906,534	14
15	Leasehold Improvements, at Historical Cos	781,266	781,266	15
16	Equipment, at Historical Cost	363,931	1,128,821	16
17	Accumulated Depreciation (book methods)	(316,491)	(1,534,481)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	9,339	9,339	22
23	Other(specify): See supplemental schedule	14,996	93,577	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 853,041	$ 3,960,233	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 971,780	$ 8,624,258	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,810	$ 432,810	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,169	46,169	28
29	Short-Term Notes Payable	1,012,794	1,012,794	29
30	Accrued Salaries Payable	285,099	285,099	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,503	18,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)	224,464	224,464	32
33	Accrued Interest Payable	42,738	76,124	33
34	Deferred Compensation	1,238	1,238	34
35	Federal and State Income Taxes	3,823	3,823	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	18,149	18,149	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,085,787	$ 2,119,173	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,767,467	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,767,467	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,085,787	$ 8,886,640	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,114,007)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 971,780	$ #REF!	48

*(See instructions.)

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	34,986	34,986
Accrued Interest Receivable		5,958
	34,986	40,944

OTHER CURRENT LIABILITIES:	Amount	Amount
PA Retro Payments	18,149	18,149
	18,149	18,149

OTHER NON CURRENT ASSETS:		
Capital Expenditure Reserve	14,996	14,996
Goodwill (net of amortization)		8,434
Loan Committment Fees (net of amort)		70,147
	14,996	93,577

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (629,441)	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (629,441)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(484,566)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (484,566)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,114,007)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	FAIRFAX NURSING HOME, INC.	#	0038752	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(629,441)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(629,441)
Equity(Deficit) from Page 17 Col 1		(1,114,007)
Related Party		
Equity(Deficit)	703979	
Income	147646	
		851,625
Combined Equity - End of Year		(262,382)

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,508,226	1
2	Discounts and Allowances for all Levels	(986,825)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,521,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	814,040	6
7	Oxygen	13,155	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 827,195	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	30	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,355	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,046	19
20	Radiology and X-Ray	1,606	20
21	Other Medical Services	1,346,535	21
22	Laundry	3,637	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 1,446,209	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,973	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,973	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,055	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,055	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,805,833	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,001,558	31
32	Health Care	2,745,046	32
33	General Administration	1,419,127	33
	B. Capital Expense		
34	Ownership	1,241,904	34
	C. Ancillary Expense		
35	Special Cost Centers	794,924	35
36	Provider Participation Fee	87,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,290,399	40
41	**Income before Income Taxes (line 30 minus line 40)****	(484,566)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (484,566)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION		AMOUNT
1	Vending Commissions		8
2	Wheelchair Rental		1,995
3	Jury Duty Income	(adjusted out on page 5)	52
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
		TOTALS	2,055

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	560	686	$ 18,060	$ 26.33	1
2	Assistant Director of Nursing	1,970	2,316	65,089	28.10	2
3	Registered Nurses	28,413	31,879	628,138	19.70	3
4	Licensed Practical Nurses	23,152	25,339	456,698	18.02	4
5	Nurse Aides & Orderlies	91,192	103,198	947,596	9.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	15,921	17,217	310,917	18.06	7
8	Rehab/Therapy Aides	6,456	7,373	85,510	11.60	8
9	Activity Director	1,896	2,099	26,572	12.66	9
10	Activity Assistants	10,545	11,498	82,882	7.21	10
11	Social Service Workers	5,569	6,311	70,267	11.13	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,096	39,123	18.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,853	20,221	157,771	7.80	15
16	Dishwashers					16
17	Maintenance Workers	4,048	4,580	56,690	12.38	17
18	Housekeepers	19,474	21,079	159,651	7.57	18
19	Laundry	10,203	11,014	94,076	8.54	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,982	9,875	124,638	12.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,920	2,196	27,574	12.56	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	251,042	278,977	$ 3,351,252 *	$ 12.01	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	242/monthly	$ 15,030	1-3	35
36	Medical Director	monthly	19,000	9-3	36
37	Medical Records Consultant	monthly	1,450	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,910	10-3	39
40	Physical Therapy Consultant	200	10,000	10A-3	40
41	Occupational Therapy Consultant	61	3,038	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	15	763	10A-3	43
44	Activity Consultant	42	1,984	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dentist		835	10-3	47
48	CCI Costs	see attached	66,110		48
49	TOTAL (lines 35 - 48)	318	$ 122,120		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	176	4,919	10-3	51
52	Nurse Aides	4,238	74,640	10-3	52
53	TOTAL (lines 50 - 52)	4,414	$ 79,559		53

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator salaries directly allocated from Care Centers, Inc.			$
See page 6			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 0

B. Administrative - Other

Description	Amount
Chris Wayer	$ 6,175
Extended Care Management	1,872
CCI Administrative Payroll (adjusted on page 6B)	74,459
TOTAL (agree to Schedule V, line 17, col. 3)	$ 82,506
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type		Amount
Winston & Strawn	Legal		$ 681
John Hardek	Legal		1,425
Alberto Saltiel	Legal	*	1,725
Frost, Ruttenberg& Rothblatt	Accounting		13,798
Alpha Data Services	Computer Services		5,008
Jacobs Healthcare	Computer Services		125
Sourcetech	Computer Services		920
Maxsourse	Computer Services		100
Personnel Planners	Unemployment Consultant		4,072
Care Centers, Inc.	various - see attached		228,850
* Adjusted out on page 5			
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed $2500 attach copy of invoices.)			$ 256,704

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,090
Unemployment Compensation Insurance	39,908
FICA Taxes	253,160
Employee Health Insurance	80,239
Employee Meals	21,740
Illinois Municipal Retirement Fund (IMRF)*	
Pension	22,759
Employee Physicals	260
Holiday Expense	2,440
Other Employee Benefits	8,154
TOTAL (agree to Schedule V, line 22, col.8)	$ 524,750

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	28,708
Health Care Worker Background Check	1,876
(Indicate # of checks performed 268)	
License & Fees	8,411
Placement Fees	11,550
Dues & Subscriptions	5,434
Advertising & Promotion	16,251
Yellow Page Advertising	669
Care Center Allocation	1,090
Less: Public Relations Expense	( )
Non-allowable advertising	(16,251)
Yellow page advertising	(669)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,069

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,570
Educational Materials	2,119
Care Center Allocation	3,868
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,557

**See instructions.

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FAIRFAX NURSING HOME, INC. # 0038752 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council of Long Term Care $4813**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,993** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **87,840**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **21,740** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **30**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Frost, Ruttenberg & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw